

## INSTRUCTIONS

**1** TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filled with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

64559

## 4604 CERTIFICATE OF DEATH

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>HARFORD</u>		MARYLAND		STATE <u>MD.</u>		COUNTY <u>HARFORD</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>HAVRE DE GRACE</u>		LENGTH OF STAY (In this place) <u>30 YRS</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>HAVRE DE GRACE</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>315 GIRARD ST.</u>				STREET ADDRESS (If rural give location) <u>315 GIRARD ST</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) (First) (Middle) (Last) <u>ANNIE</u> <u>ALLEN</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>APRIL 18</u> 19 <u>60</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>JAN. 15, 1898</u>	9. AGE last birthday <u>82</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>M. D.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>UNKNOWN</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT & ADDRESS <u>HARFORD CO. WELFARE</u> <u>BEL AIR MD.</u>			
<b>18. MEDICAL CERTIFICATION</b>						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.1 IMMEDIATE CAUSE (A) <u>Pulmonary Edema</u>						<u>15 months</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Coronary Occlusion -</u>						<u>1 hour</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Chronic Myocarditis with Hypertension</u>						<u>15 years</u>	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June</u> , 19 <u>57</u> , to <u>April</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>April 18</u> , 19 <u>60</u> , and that death occurred at <u>4:30 P.</u> M, from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u> M.D.				ADDRESS (Street, city, town, state) <u>HAVRE DE GRACE</u>		DATE SIGNED <u>April 19, 1960</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>	DATE THEREOF <u>4-21-1960</u>	NAME OF CEMETERY OR CREMATORY <u>ANGEL HILL</u>		LOCATION (City, town, or county) (State) <u>HAVRE DE GRACE MD.</u>			
24. REC'D BY REGISTRAR DATE <u>APR 22 '60</u>	REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		ADDRESS <u>MD. HAVRE DE GRACE</u>		

# CERTIFICATE OF DEATH

Form No. 100

For use in the State of Maryland

<p>1. Name of deceased: _____</p>	
<p>2. Sex: _____</p>	
<p>3. Age: _____</p>	
<p>4. Date of death: _____</p>	
<p>5. Place of death: _____</p>	
<p>6. Cause of death: _____</p>	
<p>7. Signature of physician: _____</p>	
<p>8. Signature of registrar: _____</p>	
<p>9. Date of registration: _____</p>	
<p>10. Registrar's name: _____</p>	
<p>11. Registrar's address: _____</p>	
<p>12. Registrar's telephone: _____</p>	
<p>13. Registrar's commission number: _____</p>	
<p>14. Registrar's expiration date: _____</p>	
<p>15. Registrar's signature: _____</p>	
<p>16. Registrar's seal: _____</p>	
<p>17. Registrar's stamp: _____</p>	
<p>18. Registrar's office: _____</p>	
<p>19. Registrar's district: _____</p>	
<p>20. Registrar's county: _____</p>	
<p>21. Registrar's state: _____</p>	
<p>22. Registrar's country: _____</p>	
<p>23. Registrar's continent: _____</p>	
<p>24. Registrar's world: _____</p>	
<p>25. Registrar's universe: _____</p>	
<p>26. Registrar's everything: _____</p>	
<p>27. Registrar's nothing: _____</p>	
<p>28. Registrar's somewhere: _____</p>	
<p>29. Registrar's nowhere: _____</p>	
<p>30. Registrar's everywhere: _____</p>	
<p>31. Registrar's anywhere: _____</p>	
<p>32. Registrar's everywhere: _____</p>	
<p>33. Registrar's anywhere: _____</p>	
<p>34. Registrar's everywhere: _____</p>	
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<p>52. Registrar's everywhere: _____</p>	
<p>53. Registrar's anywhere: _____</p>	
<p>54. Registrar's everywhere: _____</p>	
<p>55. Registrar's anywhere: _____</p>	
<p>56. Registrar's everywhere: _____</p>	
<p>57. Registrar's anywhere: _____</p>	
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<p>90. Registrar's everywhere: _____</p>	
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<p>92. Registrar's everywhere: _____</p>	
<p>93. Registrar's anywhere: _____</p>	
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<p>96. Registrar's everywhere: _____</p>	
<p>97. Registrar's anywhere: _____</p>	
<p>98. Registrar's everywhere: _____</p>	
<p>99. Registrar's anywhere: _____</p>	
<p>100. Registrar's everywhere: _____</p>	

REMARKS

1. Name of deceased: \_\_\_\_\_

2. Sex: \_\_\_\_\_

3. Age: \_\_\_\_\_

4. Date of death: \_\_\_\_\_

5. Place of death: \_\_\_\_\_

6. Cause of death: \_\_\_\_\_

7. Signature of physician: \_\_\_\_\_

8. Signature of registrar: \_\_\_\_\_

9. Date of registration: \_\_\_\_\_

10. Registrar's name: \_\_\_\_\_

11. Registrar's address: \_\_\_\_\_

12. Registrar's telephone: \_\_\_\_\_

13. Registrar's commission number: \_\_\_\_\_

14. Registrar's expiration date: \_\_\_\_\_

15. Registrar's signature: \_\_\_\_\_

16. Registrar's seal: \_\_\_\_\_

17. Registrar's stamp: \_\_\_\_\_

18. Registrar's office: \_\_\_\_\_

19. Registrar's district: \_\_\_\_\_

20. Registrar's county: \_\_\_\_\_

21. Registrar's state: \_\_\_\_\_

22. Registrar's country: \_\_\_\_\_

23. Registrar's continent: \_\_\_\_\_

24. Registrar's world: \_\_\_\_\_

25. Registrar's universe: \_\_\_\_\_

26. Registrar's everything: \_\_\_\_\_

27. Registrar's nothing: \_\_\_\_\_

28. Registrar's somewhere: \_\_\_\_\_

29. Registrar's nowhere: \_\_\_\_\_

30. Registrar's everywhere: \_\_\_\_\_

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47. Registrar's anywhere: \_\_\_\_\_

4605

## CERTIFICATE OF DEATH

Reg. Dist. No.

64560

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVER DE GRACE</u>				c. LENGTH OF STAY IN 1b <u>1 day</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Forest Hill</u>				d. STREET ADDRESS <u>Grier Nursery Road</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD MEMORIAL Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>SABIE</u> Middle <u>MAY</u> Last <u>BLACK</u>				4. DATE OF DEATH Month <u>April</u> Day <u>12</u> Year <u>1960</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>October 20, 1888</u>	
9. AGE (In years lost birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>12</u> Hours <u>12</u> Min.		IF UNDER 24 HRS. Hours <u>12</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Housework</u>		11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>JAMES BLACK HALL</u>				14. MOTHER'S MAIDEN NAME <u>JESTINE Burris</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>INFORMANT Husband - Mr John F. Black</u>			
17. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Decompensation</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive and arteriosclerotic</u> DUE TO (c) <u>Cardiovascular disease</u> Pneumonitis INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>&gt; 1 year</u>				18. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pneumonitis</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>Harford</u> (County) <u>Harford</u> (State) <u>Md.</u>							
21. I certify that I attended the deceased from <u>April 12th, 1960</u> to <u>April 12, 1960</u> that I last saw the deceased alive on <u>April 12th, 1960</u> , and that death occurred at <u>9:30 P.M.</u> from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <u>211 N. Union Ave. Harford Co., Maryland</u>			
ACTUAL SIGNATURE <u>Edward C. Loo, M.D.</u>				DATE SIGNED <u>4/12/60</u>			
PHYSICIAN'S NAME (Type) <u>Edward C. Loo, M.D.</u>				<u>Haver de Grace, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>April 15, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial Gardens</u>		22d. LOCATION (City, town, or county) (State) <u>Bel Air, Harford Co., Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph W. Foster</u>				ADDRESS <u>W. Broadway + William St. Bel Air, Maryland</u>		24a. REC'D BY REGISTRAR <u>Arthur L. Hanna</u>	
24b. REGISTRAR'S SIGNATURE				DATE <u>APR 18 '60</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

440x

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
4621  
CERTIFICATE OF DEATH

64561

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Barlington</u>				c. LENGTH OF STAY IN TB <u>34 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. STREET ADDRESS <u>1</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>James Emanuel Bostic</u>				4. DATE OF DEATH Month Day Year <u>April 13, 1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec 23, 1884</u>	
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House painter</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Harford Co, Md</u>			
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Joseph F. Bostic</u>				14. MOTHER'S MAIDEN NAME <u>Hannah Major</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>214-15-6309</u>			
17. INFORMANT <u>Wm Bostic</u>				Address <u>Barlington Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Heart Condition</u> DUE TO <u>Natural</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>✓</u>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>✓</u>			
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. <u>✓ 19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Barlington Md</u>	
20f. (City or town) <u>Barlington</u>				20g. (County) <u>Harford Co</u>		20h. (State) <u>Md</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>April 8, 1960</u> to <u>April 13, 1960</u> , that (I) (we) last saw the deceased alive on <u>April 12, 1960</u> , and that death occurred at <u>7 A.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>F.P. Snodgrass</u>				22b. DATE SIGNED <u>4/14/60</u>			
22c. PHYSICIAN'S NAME (Type) <u>F.P. Snodgrass</u>				22d. ADDRESS <u>Barlington Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Barlington Md</u>				23b. DATE THEREOF <u>April 15, 1960</u>			
23c. NAME OF CEMETERY OR CREMATORY <u>Barlington Co Md</u>				23d. LOCATION (City, town, or county) (State) <u>Harford Co Md</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Art. Bailey</u>				25. REC'D BY REGISTRAR <u>APR 20 '60</u>			
25a. ADDRESS <u>Barlington Md</u>				25b. REGISTRAR'S SIGNATURE <u>Arthur L. Howard</u>			



4606

## CERTIFICATE OF DEATH

64562

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAURE DE GRACE</u>				c. LENGTH OF STAY IN 1b <u>4 1/2 HRS.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD MEMORIAL HOSP.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>ALICE</u> Middle <u>BOYD</u> Last <u>BOYD</u>				4. DATE OF DEATH Month <u>April</u> Day <u>22</u> Year <u>1960</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-14-66</u>	
9. AGE (In years last birthday) <u>94</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Andrew Famous</u>				14. MOTHER'S MAIDEN NAME <u>MARY CARR</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>  </u>			
INFORMANT <u>ALVIN BOYD</u>				Address <u>STREET, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hemorrhage from</u> DUE TO (c) <u>Carcinoma of JAW</u>							INTERVAL BETWEEN ONSET AND DEATH <u>4 1/2 hrs</u>  <u>2 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month <u>  </u> Day <u>  </u> Year <u>19</u> Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>MARCH 1954</u> to <u>April 22, 1960</u> , that I last saw the deceased alive on <u>APRIL 22</u> , 19 <u>60</u> , and that death occurred at <u>12:30 A.M.</u> from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>Darlington, Md</u>				DATE SIGNED <u>4/22/60</u>			
ACTUAL SIGNATURE <u>Dudley Phillips</u>				M.D. <u>Darlington, MD</u>			
PHYSICIAN'S NAME (Type) <u>Dudley Phillips</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4-25-1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Emory</u>		22d. LOCATION (City, town, or county) (State) <u>STREET, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Perkins, Delta, Pa.</u>				24a. REC'D BY REGISTRAR DATE <u>APR 26 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Charles E. Kiser</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

HP 10-11-12

10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

4622

## CERTIFICATE OF DEATH

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Harford</u> MARYLAND				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Darlington Rural</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Darlington Rural</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Stafford Road</u>				d. STREET ADDRESS <u>1 Stafford Road</u>			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
<b>3. NAME OF DECEASED</b> (Type or print) First <u>CORNELIA</u> Middle <u>T.</u> Last <u>CAMERON</u>				<b>4. DATE OF DEATH</b> Month <u>April</u> Day <u>19</u> Year <u>1960</u>			
<b>5. SEX</b> <u>F</u>		<b>6. COLOR OR RACE</b> <u>W</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>Dec. 5, 1864</u>	
<b>9. AGE</b> (In years last birthday) <u>95</u> yrs.		<b>IF UNDER 1 YEAR</b> Months Days Hours Min.		<b>IF UNDER 24 HRS.</b> Months Days Hours Min.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>NONE</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Housewife</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>St. Louis, Missouri</u>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U. S. A.</u>							
<b>13. FATHER'S NAME</b> <u>Joseph Tilford</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Cornelia DEAN</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or date of service) <u>NO</u>				<b>16. SOCIAL SECURITY NO.</b> <u>                    </u>		<b>17. INFORMANT</b> <u>Mrs. Buckner M. Creel</u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>794X</u> DUE TO <u>Old Age</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>                    </u> DUE TO <u>                    </u> (c) <u>                    </u> DUE TO <u>                    </u>				INTERVAL BETWEEN ONSET AND DEATH <u>104AS</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <u>19</u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	
<b>20f. (City or town)</b> (County) (State)							
<b>21. I certify that I attended the deceased from</b> <u>MAY 1947</u> <b>to</b> <u>APRIL 19, 1960</u> <b>that I last saw the deceased alive on</b> <u>APRIL 15</u> <b>19</b> <u>60</u> <b>and that death occurred at</b> <u>7 PM</u> <b>M, from the causes and on the date stated above.</b>							
<b>ACTUAL SIGNATURE</b> <u>Dudley Phillips MD</u> <b>M.D.</b> <u>Darlington, Md</u>				<b>ADDRESS</b> (Street, city or town, state) <u>Stafford Road Darlington, Maryland</u>			
<b>PHYSICIAN'S NAME</b> (Type) <u>Darlington, Md</u>				<b>DATE SIGNED</b> <u>Dudley Phillips MD</u>			
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>April 22, 1960</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Arlington National Cemetery</u>		<b>22d. LOCATION</b> (City, town, or county) (State) <u>Arlington Virginia</u>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Joseph W. Foster</u> <b>ADDRESS</b> <u>W. Broadway + Williams St. Bel Air, Maryland</u>				<b>24a. REC'D BY REGISTRAR</b> <u>                    </u> <b>DATE</b> <u>APR 22 '60</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur L. Kline</u>	

# CERTIFICATE OF DEATH

WILLIAM

JOHN

1

4607

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>HARFORD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVERDIE GRACE</u>				c. LENGTH OF STAY IN 1b <u>2 DAYS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD HOSPITAL</u>				e. STREET ADDRESS <u>119 HAWTHORNE RD</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARGUERITE</u> <u>MAE</u> <u>CARTER</u>				4. DATE OF DEATH Month Day Year <u>APRIL</u> <u>11</u> <u>1960</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>NEGRO</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>APRIL 2, 1942</u>	
9. AGE (In years last birthday) yrs. <u>18</u>		10. IF UNDER 1 YEAR Months Days Hours Min <u>5</u> <u>15</u> <u>00</u> <u>00</u>		11. IF UNDER 24 HRS Hours Min <u>00</u> <u>00</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME <u>JOHN N. CARTER JR.</u>				14. MOTHER'S MAIDEN NAME <u>FELICIA</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO <u>NONE</u>		INFORMANT Address <u>Edgewood, Md.</u> <u>Mr. John N. Carter, Jr. 119 Hawthorne Rd</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>754.5</u> DUE TO <u>Congenital Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Meningitis</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>4-2</u> , 19 <u>60</u> , to <u>4-11</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>4-11</u> , 19 <u>60</u> , and that death occurred at <u>2:34</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John N. Carter Jr.</u>				ADDRESS (Street, city and town, state) <u>119 Hawthorne Rd, Edgewood, Md.</u>			
DATE SIGNED <u>4/11/60</u>							
PHYSICIAN'S NAME (Type) <u>Chas. J. Bullock</u>				ADDRESS <u>Haverd Grace, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-13-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Berkley Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Chas. J. Bullock</u>				ADDRESS <u>Haverd Grace, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 14 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur E. Kane</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed in the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

20071321XV4

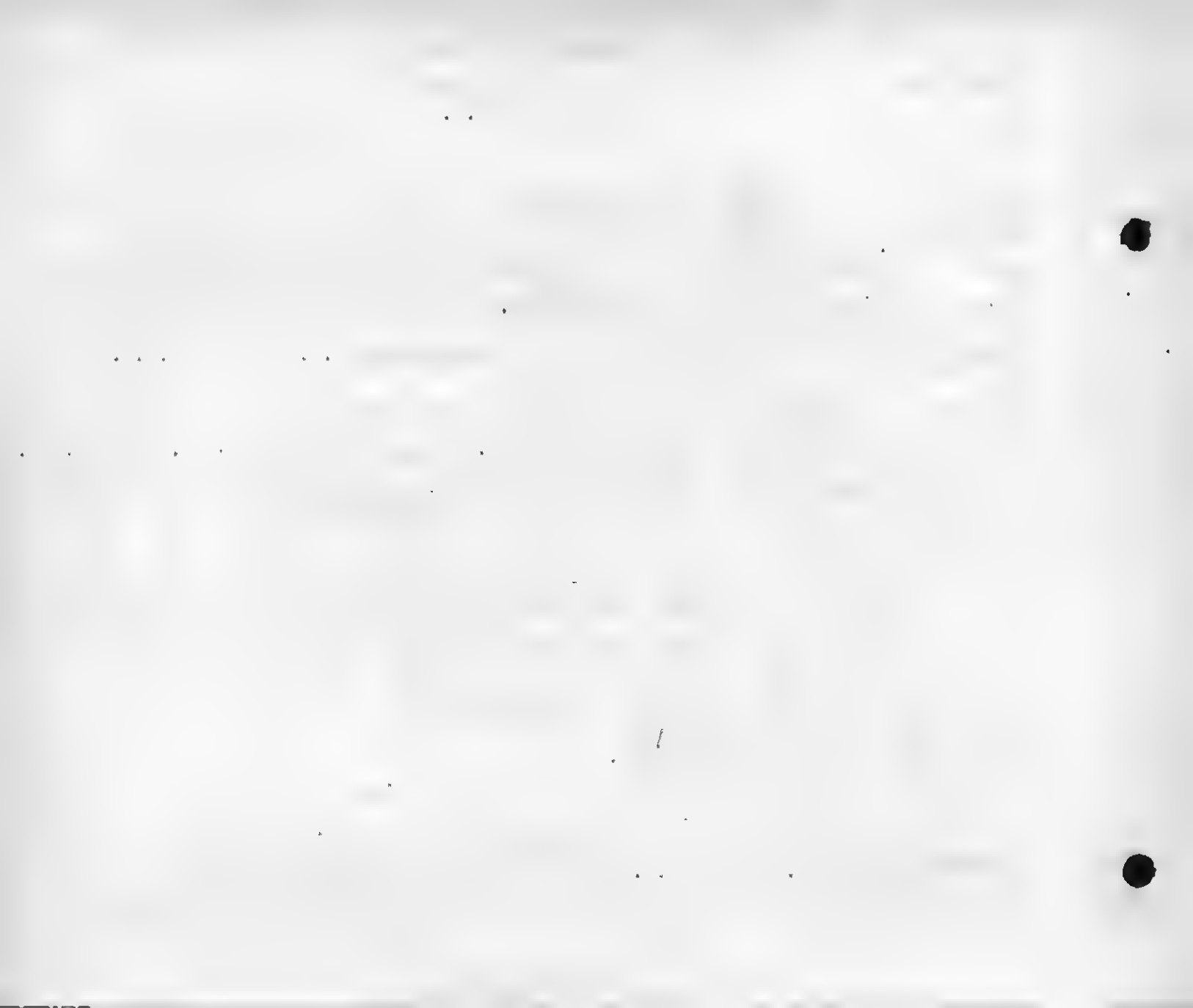
7545

4601 CERTIFICATE OF DEATH

64566

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>			
c. LENGTH OF STAY IN 1b <u>20 miles</u>				d. STREET ADDRESS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford County Home, Toll Gate Rd., Bel Air</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Benjamin</u> Middle <u>Davis</u> Last				4. DATE OF DEATH Month <u>April</u> Day <u>19</u> Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 4, 1873</u>	
9. AGE (In years last birthday) <u>86</u> yrs		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>unknown</u>				14. MOTHER'S MAIDEN NAME <u>unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Clark E. Fitzpatrick, Toll Gate Rd., Bel Air, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Coronary Thrombosis, <del>myocardial infarction</del></u> DUE TO (b) <u>Chronic cardio-vascular disease</u> DUE TO (c) <u>?</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				INTERVAL BETWEEN ONSET AND DEATH <u>30 minutes</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>?</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Jan. 2</u> , 19 <u>40</u> , to <u>April 19</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>April 11</u> , 19 <u>60</u> , and that death occurred at <u>5:00 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Forest Hill, Md.</u> DATE SIGNED <u>April 19, 1960</u>							
ACTUAL SIGNATURE <u>Willard P. Hudson</u> M.D.				PHYSICIAN'S NAME (Type) <u>Willard P. Hudson, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>4-19-60</u>		<u>4-19-60</u>		<u>Woodward v. of Md. School</u>		<u>Baltimore 12, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
				<u>APR 22 '60</u>		<u>Arthur S. [Signature]</u>	



4602 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

4567

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>		c. LENGTH OF STAY IN TB <u>2 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford County Almshouse</u>				d. STREET ADDRESS <u>Harford County Almshouse</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>Dimong</u> Last <u></u>				4. DATE OF DEATH Month <u>April</u> Day <u>11</u> Year <u>1960</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 2, 1872</u>	
9. AGE <u>87</u> yrs.		10. IF UNDER 1 YEAR Months <u></u> Days <u></u>		11. IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Proprietor</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Ice &amp; Fish</u>		11. BIRTHPLACE (State or foreign country) <u>Philadelphia, Pa.,</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.,</u>							
13. FATHER'S NAME <u>William Dimong</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>John A. Dimong, 3759 N. 10th St., Phila., Pa.,</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic C V disease</u>							
422.1 DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u></u>							
DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u></u> a. m. <u></u> p. m. <u></u> Month, Day, Year <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>Bel Air, Md</u>				20g. (County) <u>Harford</u>		20h. (State) <u>Md</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Gerald C Palmer</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air, Md</u> DATE SIGNED <u>4-12-60</u>			
EXAMINER'S NAME (Type) <u>Gerald C Palmer</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>April 13, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Francis</u>		22d. LOCATION (City, town, or county) (State) <u>Abingdon, Harford, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard L. Brown Jr</u>				45a. REC'D BY REGISTRAR DATE <u>APR 14 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be completed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

450.0

4608

## CERTIFICATE OF DEATH

64568

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town.) <u>HARVEY DE GRACE</u>				c. LENGTH OF STAY IN 1b <u>1 1/2 DAYS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD MEMORIAL HOSP.</u>				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <u>CARRIE</u> Middle <u>BELL</u> Last <u>FOYLEMAN</u>				4. DATE OF DEATH Month <u>Apr.</u> Day <u>1</u> Year <u>1960</u>			
5 SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-19-1884</u>	9. AGE (In years last birthday) <u>75</u> yrs	IF UNDER 1 YEAR Months <u>7</u> Days <u>12</u> Hours <u>12</u> Min	IF UNDER 24 HRS Months <u>7</u> Days <u>12</u> Hours <u>12</u> Min	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>
10b. KIND OF BUSINESS OR INDUSTRY <u>Canning Co.</u>			11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>JAMES R. PATRICK</u>			14. MOTHER'S MAIDEN NAME <u>JILLIE HESS</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>			16. SOCIAL SECURITY NO. <u>220-14-1767</u>		17. INFORMANT Address <u>Mrs John L. Madron Coloma, Md.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Esophageal Varices</u> <u>294X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Polycthemia Vera</u> DUE TO (c)							<u>1 week</u> <u>2 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
20f. (City or town)			(County)		(State)		
21. I certify that I attended the deceased from <u>4/2</u> , 19 <u>60</u> , to <u>4/22</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>4/22</u> , 19 <u>60</u> , and that death occurred at <u>11:55</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Neil Taylor</u> M.D.			ADDRESS (Street, city or town, state) <u>Rising Sun, Md</u>				
PHYSICIAN'S NAME (Type) <u>Neil Taylor</u> M.D.			DATE SIGNED <u>4/14/60</u>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4-16-1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Oakwood Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Conowingo Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Vernon E. McMillen</u>			ADDRESS <u>Rising Sun Md.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 18 1960</u>		
					24b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11/1

4623

CERTIFICATE OF DEATH

64569

Reg. Dist. No. 2

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FALLSTON</u>				c. LENGTH OF STAY IN 1b <u>1 Month</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>FALLSTON Road</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FALLSTON</u>			
3. NAME OF DECEASED (Type or print) First <u>SADIE</u> Middle <u>JOHNSON</u> Last <u>GARDNER</u>				4. DATE OF DEATH Month <u>APRIL</u> Day <u>15</u> Year <u>1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>November 5, 1888</u>	
9. AGE (In years last birthday) <u>71</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) <u>New York City</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ALEXANDER JOHNSON</u>				14. MOTHER'S MAIDEN NAME <u>(UNKNOWN)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>MILDRED WILLINGHAM (daughter)</u>				Address <u>FALLSTON, ME.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CEREBRAL Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>GENERALIZED ARTERIOSCLEROSIS</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>5 or 6 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertension ; Old fracture of left hip, with non-union (54 yrs ago)</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>MARCH 22, 1960</u> , to <u>APRIL 15, 1960</u> , that I last saw the deceased alive on <u>APRIL 15, 1960</u> , and that death occurred at <u>7:25 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Paul S. Stonesifer Jr.</u>				ADDRESS (Street, city or town, state) <u>115 FULFORD AVE. BEL AIR, MD.</u>			
PHYSICIAN'S NAME (Type) <u>PAUL S. STONESIFER JR.</u>				DATE SIGNED <u>APRIL 15 1960</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>4/19/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Harpurville</u>		22d. LOCATION (City, town, or county) (State) <u>Harpurville N. Y.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Parryson M. Ford Chas. Md.</u>				24a. REC'D BY REGISTRAR DATE <u>APR 19 1960</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

332X

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4624

## CERTIFICATE OF DEATH

64570

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Harford</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived If institution Residence before adm ssion) a. STATE <b>Md.</b> b. COUNTY <b>Harford</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Whiteford</b>		c. LENGTH OF STAY IN 1b <b>67 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>WARREN</b> Middle <b>CRANMER</b> Last <b>GLASGOW</b>		4. DATE OF DEATH Month <b>April</b> Day <b>6</b> Year <b>1960</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 16, 1892</b>
9. AGE (In years last birthday) <b>67 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mechanic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Auto</b>	
11. BIRTHPLACE (State or foreign country) <b>Delta, Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William E. Glasgow</b>		14. MOTHER'S MAIDEN NAME <b>Dollie LaRue</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>216-32-7629</b>	
17. INFORMANT <b>Mildred Glasgow, Whiteford, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>20 catches melleitis</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1941</b> to <b>April 6, 1960</b> , that I last saw the deceased alive on <b>April 5, 1960</b> , and that death occurred at <b>4:00</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Joseph H. Hunt</b> M.D.		ADDRESS (Street, city or town, state) <b>Delta, Pa.</b> DATE SIGNED <b>4/7/60</b>	
PHYSICIAN'S NAME (Type) <b>Joseph H. Hunt</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Apr. 9, 1960</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Slate Ridge</b>	22d. LOCATION (City, town, or county) (State) <b>Delta, Penna.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John H. Harkins</b> ADDRESS <b>Delta, Penna.</b>		24a. REC'D BY REGISTRAR <b>APR 11 '60</b>	24b. REGISTRAR'S SIGNATURE <b>William L. Harkins</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

4625

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen				c. LENGTH OF STAY IN 1b 1 Yr 9 Mos			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION US Army Hospital Aberdeen Proving Ground, Md				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) ROBERT First D. Middle HANCOCK SR Last				4. DATE OF DEATH April 2 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 24 December 1915	
9. AGE (In years last birthday) 44 yrs		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Army				10b. KIND OF BUSINESS OR INDUSTRY N/A		11. BIRTHPLACE (State or foreign country) Rhode Island	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Frederick T Hancock Sr				14. MOTHER'S MAIDEN NAME Margaret Ann Bradley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO 138 to 1960		17. UNKNOWN	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Infarction of Myocardium DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) Unknown PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None				INTERVAL BETWEEN ONSET AND DEATH 13 Days			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 2 March 1960, to 2 April 1960, that I last saw the deceased alive on 1 April 1960, and that death occurred at 7:00 AM, from the causes and on the date stated above.							
ACTUAL SIGNATURE Joseph A Grossman M.D.				DATE SIGNED 2 April '60 USAH 2 Apr 60			
PHYSICIAN'S NAME (Type) JOSEPH A GROSSMAN Capt LC				ADDRESS (Street, city or town, state) Aberdeen Proving Ground, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 4-4-60		22c. NAME OF CEMETERY OR CREMATORY Pawtucket		22d. LOCATION (City, town, or county) (State) Pawtucket, Rhode Island.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook Blight Inc. 6009 Harford Rd. (14)				24a. REC'D BY REGISTRAR DATE APR 5 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Hines	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

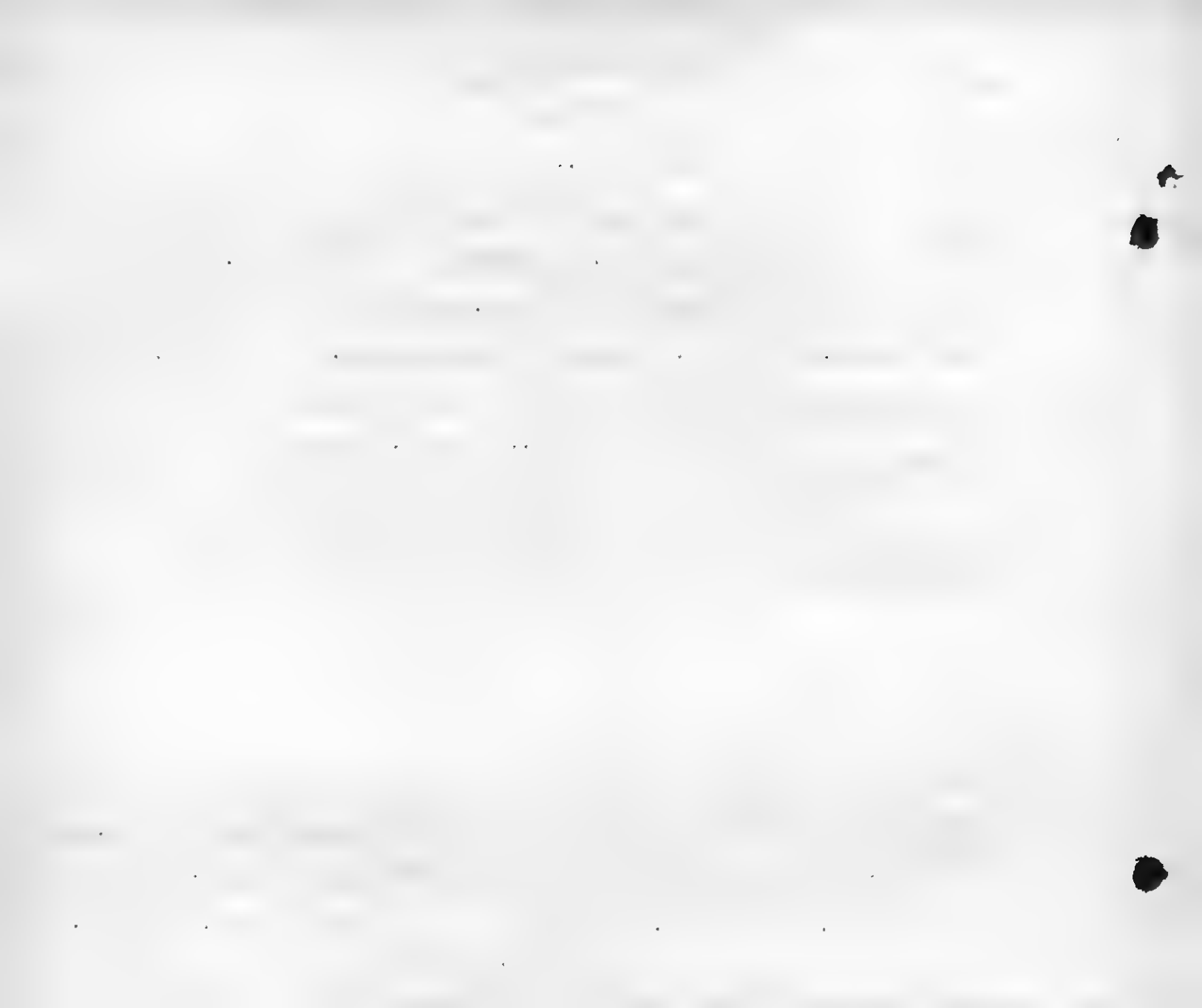
4626

## CERTIFICATE OF DEATH

64572

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Joppa</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Joppa</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>Valentine</u> Middle <u>G.</u> Last <u>Hartman</u>		4. DATE OF DEATH Month <u>Apr.</u> Day <u>19</u> Year <u>1960</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 4, 1894</u>
9. AGE (In years last birthday) <u>65</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Operating Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt.,</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.,</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.,</u>	
13. FATHER'S NAME <u>Valentine Hartman</u>		14. MOTHER'S MAIDEN NAME <u>Bertha Hannock</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>212-26-0497</u>	
17. INFORMANT <u>Mrs., Regina A. Hartman,</u>		Address <u>Joppa, Md.,</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Atherosclerosis</u> DUE TO (c) <u>Atherosclerotic C-V Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>4 yrs</u> <u>6 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month <u>  </u> Day <u>  </u> Year <u>19</u> Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept 4, 1942</u> to <u>April 19, 1960</u> , that I last saw the deceased alive on <u>April 3, 1960</u> , and that death occurred at <u>4 P. M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Churchville, Maryland</u> DATE SIGNED <u>Apr. 19, 1960</u>			
ACTUAL SIGNATURE <u>J. Ralph Horky</u>		M. D. <u>Churchville, Maryland</u>	
PHYSICIAN'S NAME (Type) <u>J. Ralph Horky</u>		<u>Churchville, Maryland.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Apr. 22, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Stephens</u>		22d. LOCATION (City, town, or county) (State) <u>Bradshaw, Balto., Maryland.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard K. Williams</u>		ADDRESS <u>Abingdon, Md.,</u>	
24a. REC'D BY REGISTRAR DATE <u>APR 25 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanks</u>	



MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4627 **CERTIFICATE OF DEATH**

64573

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>Harford</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Harford</b>	
CITY (If outside corporate limits, write RURAL or end give nearest town) <b>Forest Hill</b>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Forest Hill</b>		OR TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b>			
(First) <b>Alice</b>		(Middle) <b>M.</b>		(Last) <b>Hess</b>		(Month) <b>April</b> (Day) <b>26</b> (Year) <b>1960</b>	
<b>5. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <b>Widowed</b>	<b>8. DATE OF BIRTH</b> <b>May 21, 1879</b>		<b>9. AGE last birthday</b> <b>80</b> yrs.	<b>IF UNDER 1 YEAR</b> Months Days	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Bristol, England</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>Arthur Sly</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Marguerite Chamberlain</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) (If Yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <b>417-38-4574</b>		<b>17. INFORMANT &amp; ADDRESS</b> <b>Arthur Hess, 111 Greenbrier Rd. Towson 4</b>			
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
<b>2. IMMEDIATE CAUSE</b> (A) <b>Coronary Occlusion</b>				<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>20 hours</b>			
<b>ANTECEDENT CAUSE(S) DUE TO</b> (B) <b>Arteriosclerotic C-V-D</b>				<b>prob. 15 years</b>			
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.</b> (C)							
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>2D. AUTOPSY?</b> -YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from</b> <u>1/25/60</u> , 19 <u>60</u> , <b>to</b> <u>1/26/60</u> , 19 <u>60</u> , <b>that I last saw the deceased alive on</b> <u>1/26/60</u> , 19 <u>60</u> , <b>and that death occurred at</b> <u>8:16 AM</u> , <b>from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <i>Robert Barth</i>				<b>ADDRESS</b> (Street, city, town, state) <b>Forest Hill, Maryland</b>		<b>DATE SIGNED</b> <b>4/26/60</b>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <b>CREMATION</b>		<b>DATE THEREOF</b> <b>4-28-60</b>		<b>NAME OF CEMETERY OR CREMATORY</b> <b>Green Mount</b>		<b>LOCATION</b> (City, town, or county) (State) <b>Baltimore</b>	
<b>24. REC'D BY REGISTRAR</b> <b>APR 28 1960</b>		<b>REGISTRAR'S SIGNATURE</b> <i>Robert A. Madsen</i>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Wm. Cook-Towson, Inc., 1050 York Road</b>			
<b>DATE</b>				<b>ZONE</b> <b>4</b>			

INSTRUCTIONS

**1** **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M



4609

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Hartford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harrods Grace</u>				c. LENGTH OF STAY IN 1b <u>8 days.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hartford Mem. Hosp.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Cyrus Eugene Hill</u>				4. DATE OF DEATH Month Day Year <u>April 20 1960</u>			
5 SEX <u>Male</u>		6 COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4/20/89</u>	
9. AGE (In years last birthday) <u>71</u> yrs		10. UNDER 1 YEAR Months Days Hours Min		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USJA. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>(ret'd) Machinist</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore City Highways</u>			
13. FATHER'S NAME <u>Cyrus Hill</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Cochran</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>W.W.I</u>				16. SOCIAL SECURITY NO. <u>W.W.I</u>			
17. INFORMANT <u>Mrs. Charles Laird</u>				Address <u>Bel Air, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Lobar pneumonia, right</u> <u>490X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>lower lobe</u> DUE TO (c) <u>1 week</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral thrombosis and left hemiplegia</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>April 12, 1960</u> to <u>April 20, 1960</u> that I last saw the deceased alive on <u>April 20, 1960</u> and that death occurred at <u>1:05 A.M.</u> from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <u>Edward C. Lee, M.D.</u>				DATE SIGNED <u>4/20/60</u>			
PHYSICIAN'S NAME (Type) <u>Edward C. Lee, M.D.</u>				ADDRESS <u>Harrods Grace, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4-23-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Moreland Memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Taylor Ave &amp; Dalesford Road</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Cook, Inc., 1217 St. Paul Street</u>				24a. REC'D BY REGISTRAR DATE <u>APR 22 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1  
FOR STATE  
HEALTH DEPT.  
TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 7/59

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
4628 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 64576											
1. PLACE OF DEATH a. COUNTY <b>Harford</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Edgewood</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>266 Everett Road</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Pennsylvania</b> b. COUNTY <b>Blair</b> ✓ c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Altoona</b> d. STREET ADDRESS <b>518 16th Street.,</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>RALPH WILLIAM HORNER</b>				4. DATE OF DEATH <b>April 24, 1960</b>				5. SEX <b>Male</b> 6. COLOR OR RACE <b>White</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <b>Feb. 18, 1897</b>				9. AGE In years (last birthday) <b>63</b> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.				10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Penn. RR</b>			
11. BIRTHPLACE (State or foreign country) <b>Centre Co., Pennsylvania</b>				12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME <b>Calvin Horner</b>			
14. MOTHER'S MAIDEN NAME <b>Carrie Glass</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW I</b>				16. SOCIAL SECURITY NO. 17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease complicated</b> <b>by aspirated stomach contents</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>DECEASE</b> (c) <b>DUE TO</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
MEDICAL CERTIFICATION 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)											
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> Medical Investigator <input checked="" type="checkbox"/> DATE SIGNED <b>4/25/60</b> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)											
ACTUAL SIGNATURE <b>Peter W. Rieckert</b> M.D. EXAMINER'S NAME (Type) <b>Peter Rieckert, M.D.</b> 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b> 22b. DATE THEREOF <b>4/25/60</b> 22c. NAME OF CEMETERY OR CREMATORY <b>Alto Rest Burial Cem.</b> 22d. LOCATION (City, town, or country) (State) <b>Altoona, Pennsylvania</b>											
23. FUNERAL DIRECTOR ADDRESS <b>Wm. Cook - Blight, Inc. 6009 Harford Road</b> 24a. REC'D BY REGISTRAR <b>APR 27 '60</b> 24b. REGISTRAR'S SIGNATURE <b>Charles S. Kraus</b>											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

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M  
X  
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4611

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

64577

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Harve de Grace</u>		c. LENGTH OF STAY IN 1b <u>about 30 yrs</u>	
d. NAME OF HOSPITAL (if not in hospital, give street address) OR INSTITUTION <u>Elizabeth Street</u>		e. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>24 Harve de Grace</u>	
3. NAME OF DECEASED (Type or print) First <u>Rudolph</u> Middle <u>C.</u> Last <u>James</u>		4. DATE OF DEATH Month <u>4</u> Day <u>27</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 22, 1916</u>
9. AGE (in years lost birthday) <u>44 yrs</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hardware Store</u>	
11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John James</u>		14. MOTHER'S MAIDEN NAME <u>Carrie Powell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? Yes, no or unknown <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>717-09 8297</u>	
17. INFORMANT <u>Mr. Elsworth James Harve de Grace, Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> DUE TO <u>Coronary thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary thrombosis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>5 months</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>4/27/60</u> to <u>4/27/60</u> that (I) (we) last saw the deceased alive on <u>4/27/60</u> and that death occurred at <u>2 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Norman Berger</u> M D		ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> 22b. DATE SIGNED <u>4/27/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>Norman Berger</u>		22d. ADDRESS <u>24 Harve de Grace, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/30/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Berkley Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Harford, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur J. Bullock - Harve de Grace, Md</u>		ADDRESS	
25a. REC'D BY REGISTRAR <u>DATE MAY 2 '60</u>		25b. REGISTRAR'S SIGNATURE <u>William S. Krause</u>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be completed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 04578

1. PLACE OF DEATH a. COUNTY <u>Harford</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford</u> c. LENGTH OF STAY IN TB d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>DOA Harford Memorial Hospital</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Hennietta Davis Jay</u> First Middle Last 4. DATE OF DEATH <u>April 30</u> 19 <u>60</u> Month Day Year		5. SEX <u>F</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>1-29-90</u> 9. AGE (In years last birthday) <u>70</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u> 13. FATHER'S NAME <u>Samuel Smith Jay</u>		10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? 14. MOTHER'S MAIDEN NAME <u>Annie Davis</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT <u>Mrs. J. Merryman Black</u> Address <u>Cockeysville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma stomach</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u> Month, Day, Year 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>5-2-60</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Spessusia</u> 22d. LOCATION (City, town, or county) (State) <u>Perryman, Maryland</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>John O. Mitchell &amp; Sons, Inc. 1900 Rutaw Place</u> ADDRESS 24a. REC'D BY REGISTRAR DATE <u>MAY 3 '60</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	



## 4629 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 64579

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Street</u>		c. LENGTH OF STAY IN TB	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>MD Rte 165</u>		d. STREET ADDRESS <u>Whiteford</u>	
3. NAME OF DECEASED (Type or print) <u>Charles Thomas Jones</u> First Middle Last		4. DATE OF DEATH <u>April 16</u> Month Day Year <u>1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT. 1, 1936</u>
9. AGE (in years last birthday) <u>23</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>CUMBERLAND, MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CHARLES W. JONES</u>		14. MOTHER'S MAIDEN NAME <u>MARGIE S. MOYER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no) <u>YES</u>		16. SOCIAL SECURITY NO. <u>215-34-1108</u>	
17. INFORMANT <u>CHARLES W. JONES, WHITEFORD, MD.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Fracture skull</u> <u>819X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Auto acc., auto-object type</u>	
20c. TIME OF INJURY Month, Day, Year <u>4-15-60</u> Hour <u>1130</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>MD Rte 165</u>	20f. (City or town) <u>Street Harford</u> (County) <u>MD</u> (State) <u>MD</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Gerald P. Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>4-16-60</u>	
EXAMINER'S NAME (Type) <u>Gerald P. Palmer - MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>4-19-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>SLATE RIDGE</u>	22d. LOCATION (City, town, or county) <u>DELTA, PA</u> (State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Harbison, Delta, Pa.</u> ADDRESS		24a. REC'D BY REGISTRAR <u>APR 19 1960</u>	24b. REGISTRAR'S SIGNATURE <u>Charles P. Hume</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files.

TO THE REGISTRAR: File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

8/19X

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4630 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

64580

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Street</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>MD Route 165</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Whiteford</u>	
3. NAME OF DECEASED (Type or print) <u>Donald Edward Jones</u>		f. STREET ADDRESS	
4. DATE OF DEATH <u>April 16 1960</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APR. 8, 1938</u>
9. AGE (In years last birthday) <u>22</u> yrs.		10. FUND YEAR	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. MARINE</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>CUMBERLAND, MD.</u>
13. FATHER'S NAME <u>CHARLES W. JONES</u>		14. MOTHER'S MAIDEN NAME <u>MARGIE S. MOYER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>YES 1955-1960</u>		16. SOCIAL SECURITY NO. <u>219-34-0323</u>	
17. INFORMANT <u>CHARLES W. JONES, WHITEFORD, MD.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture skull</u> 819X DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Auto accident, auto-object type</u>	
20c. TIME OF INJURY Hour <u>4:30</u> p.m. Month <u>4</u> Day <u>15</u> Year <u>1960</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Route 165</u>	20f. (City or town) <u>Street Harford</u> (County) <u>MD</u> (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerold C Palmer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air</u>	
EXAMINER'S NAME (Type) <u>Gerold C Palmer M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> <u>M</u>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION <u>BURIAL</u> (Specify)		22b. DATE THEREOF <u>4-19-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>SLATE RIDGE</u>		22d. LOCATION (City, town, or county) <u>DELTA, PA.</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Harkins, Delta, Pa.</u>		24a. REC'D BY REGISTRAR <u>APR 19 1960</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur J. Hume</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

819X

4612

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre de Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre de Grace</u>	
c. LENGTH OF STAY IN 1b <u>Lifetime</u>		d. STREET ADDRESS <u>734 Otsego Street</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>734 Otsego Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Edmond</u> Middle <u>L</u> Last <u>Jones</u>		4. DATE OF DEATH Month <u>4</u> Day <u>20</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 14, 1890</u>
9. AGE (In years last birthday) <u>69</u> yrs.		10. IF UNDER 1 YEAR Months <u>9</u> Days <u>6</u> Hours <u></u> Min <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Common Labor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	
11. BIRTHPLACE (State or foreign country) <u>Harre de Grace, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>William Jones</u>		14. MOTHER'S MAIDEN NAME <u>Celestia Bowser</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u></u>		16. SOCIAL SECURITY NO. <u>220-032483</u>	
17. INFORMANT <u>Mrs. William Jones</u>		Address <u>738 Otsego St. Harre de Grace, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u>Hypertensive Arteriosclerotic Heart disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u></u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u></u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) (County) (State) <u></u>	
21. I certify that I attended the deceased from <u>11/12</u> , 19 <u>59</u> , to <u>4/20</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>4/20</u> , 19 <u>60</u> , and that death occurred at <u>2:30</u> P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>George T. Stansbury</u> M.D.		ADDRESS (Street, city or town, state) <u>509 Revolution St. Harre de Grace, Md.</u>	
DATE SIGNED <u>4/21/60</u>			
PHYSICIAN'S NAME (Type) <u>George T. Stansbury</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4-23-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. James Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Harre de Grace, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Elmer E. Bullock</u>		ADDRESS <u>Harre de Grace, Md.</u>	
24a. REC'D BY REGISTRAR <u>APR 25 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



4631

## CERTIFICATE OF DEATH

64582

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rocks</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rocks</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Grace Stanley Knopp</u>		4. DATE OF DEATH Month Day Year <u>April 19, 1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 18, 1874</u>
9. AGE (In years last birthday) <u>85</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Harford Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>David Boyd</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Campbell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>---</u>		16. SOCIAL SECURITY NO. <u>---</u>	
17. INFORMANT <u>Mrs Lottie Mohr Catonsville, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the colon</u> <u>153.8</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>September 2, 1951</u> to <u>April 19, 1960</u> , that I last saw the deceased alive on <u>April 15, 1960</u> , and that death occurred at <u>5:15 a.m.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Willard P. Hudson</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>Forest Hill, Md. April 19, 1960</u>	
PHYSICIAN'S NAME (Type) <u>Willard P. Hudson, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/22/1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>William Watters</u>	22d. LOCATION (City, town, or county) (State) <u>Cooptown Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles C. Rust</u>		ADDRESS <u>Jarrettville, Md.</u>	
24a. REC'D BY REGISTRAR <u>APR 21 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Willard P. Hudson</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



4632

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Harford</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Edgewood</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Edgewood</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <b>Pine Street</b>	
3. NAME OF DECEASED (Type or print) <b>Heinrich</b> First <b>Kolmar</b> Middle Last		4. DATE OF DEATH Month <b>Apr.</b> Day <b>3</b> Year <b>19 60</b>	
5 SEX <b>male</b>	6 COLOR OR RACE <b>white</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>Nov. 24, 1885</b>
9 AGE (In years last birthday) <b>74</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Watchmaker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Manufacturer</b>	
11. BIRTHPLACE (State or foreign country) <b>Sag Harbor, N.Y.,</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.,</b>	
13 FATHER'S NAME <b>Unknown</b>		14 MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16 SOCIAL SECURITY NO. <b>none</b>	
17 INFORMANT <b>Emanuel Shapiro</b>		Address <b>Edgewood Md.,</b>	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>723.0</b> DUE TO <b>Gasping Asphyxia, Extremities Marked</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Cerebral Thrombosis, Hypertension</b> (c) <b>Arteriosclerosis, Hypertension</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>3/15</b> , 19 <b>60</b> , to <b>3/20</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>3/20</b> , 19 <b>60</b> , and that death occurred at <b>P. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Box 966 Edgewood Md.</b> DATE SIGNED <b>4/4/60</b>			
ACTUAL SIGNATURE <b>E. Louis Kahan</b> M.D.		PHYSICIAN'S NAME (Type) <b>E. Louis Kahan</b> <b>Edgewood Maryland.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Apr. 6, 1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Md.,</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Howard R. McCombs</b>		ADDRESS <b>Abingdon, Md.</b>	
24a. REC'D BY REGISTRAR <b>APR 7 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kahan</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please give the carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



11  
FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

Item 18 File 261  
4633  
MAYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 64584

1. PLACE OF DEATH  
a. COUNTY **Harford** **MARYLAND**  
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) **Street**  
c. LENGTH OF STAY IN It  
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) **U. S. Route 1**

2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission)  
a. STATE **Maryland** b. COUNTY **Baltimore**  
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **Middle River**  
d. STREET ADDRESS **24 Cockpit Street** e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) **HARRY G. MARSH**  
4. DATE OF DEATH **April 11 1960**  
5. SEX **Male** 6. COLOR OR RACE **White** 7. MARRIED ☒ NEVER MARRIED ☐ 8. DATE OF BIRTH **12-15-1893** 9. AGE (In years last birthday) **66** yrs. 10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Mechanic** 10b. KIND OF BUSINESS OR INDUSTRY **Aircraft** 11. BIRTHPLACE (State or foreign country) **New York** 12. CITIZEN OF WHAT COUNTRY? **U.S.A.**

13. FATHER'S NAME **Henry Marsh** 14. MOTHER'S MAIDEN NAME **Victoria Unknown**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) **189-09-7048A** 16. SOCIAL SECURITY NO **189-09-7048A** 17. INFORMANT **Mrs Harry Marsh** Address **24 Cockpit Street**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) **Cor Pulmonale**  
241X DUE TO  
Conditions, if any, which gave rise to immediate cause (b) **Bronchial Asthma**  
(c), stating the underlying cause last. DUE TO

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II. of item 18.)  
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐  
CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☒ DATE SIGNED **4/12/60**  
DEPUTY MEDICAL EXAMINER ☐

ACTUAL SIGNATURE **Charles S. Petty** M.D. EXAMINER'S NAME (Type) **Charles S. Petty, M.D.** Address (Street, city, town, or county)  
22a. BURIAL, CREMATION, REMOVAL (Specify) **Burial** 22b. DATE THEREOF **4-14-1960** 22c. NAME OF CEMETERY OR CREMATORY **Cedar Lawn Cemetery** 22d. LOCAT ON (City, town, or country) (State) **Lancaster Pa.**

23. FUNERAL DIRECTOR **Lassell Funeral Home 7401 Belair Road** ADDRESS **DATE APR 13 '60** 24a. REC'D BY REGISTRAR **Arthur S. House** 24b. REGISTRAR'S SIGNATURE



4634  
 MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
 CERTIFICATE OF DEATH

64585

1. PLACE OF DEATH a. COUNTY <b>HARFORD</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institut an: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>HARFORD</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL HAYRE DE GRACE</b>		c. LENGTH OF STAY IN 1b <b>5 MO.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>R.E. Star Route</b>		e. STREET ADDRESS <b>1 R.E. Star Route</b>	
3. NAME OF DECEASED (Type or print) First <b>KATE</b> Middle <b>VAN LIEW</b> Last <b>MATCOON</b>		4. DATE OF DEATH Month <b>APRIL</b> Day <b>28</b> Year <b>1960</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>OCT. 5, 1876</b>
9. AGE (In years last birthday) <b>83</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>		11b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>	
11c. BIRTHPLACE (State or foreign country) <b>N.Y.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>EDSON VAN LIEW</b>		14. MOTHER'S MAIDEN NAME <b>MARY SUNDERLIN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>—</b> (If yes, give war or dates of service) <b>—</b>		16. SOCIAL SECURITY NO. <b>—</b>	
17. INFORMANT <b>Mrs. Fred R. Cordua</b>		Address <b>HAYRE DE GRACE STARROUTE, MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>434.4 CARDIAC ARREST</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>CARDIAC DECOMPENSATION</b> DUE TO (c) <b>1 YEAR</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>0</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>0</b> m. <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Sept. 1959</b> to <b>4-28</b> 19 <b>60</b> , that (I) (we) last saw the deceased alive on <b>4-28</b> 19 <b>60</b> , and that death occurred on <b>4-28</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>GUNTHER D. HIRSCH</b> M.D.		22b. DATE SIGNED <b>4-29-60</b>	
22c. PHYSICIAN'S NAME (Type) <b>GUNTHER D. HIRSCH</b>		22d. ADDRESS <b>803 G. B. ST HAYRE DE GRACE</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>CREMATION</b>		23b. DATE THEREOF <b>MAY 2, 1960</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>LODGE PARK CEM.</b>		23d. LOCATION (City, town, or county) (State) <b>BALTIMORE MD.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>R. Madison Mitchell</b>		25a. REC'D BY REGISTRAR <b>MAY 3 '60</b>	
ADDRESS <b>HAYRE DE GRACE MD</b>		25b. REGISTRAR'S SIGNATURE <b>Christina L. Howard</b>	

MEDICAL CERTIFICATION



**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

4625

64586

1 PLACE OF DEATH a. COUNTY <b>Harford</b> <b>MARYLAND</b>				2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Aberdeen</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital give street address) <b>US Army Hospital Aberdeen Proving Ground, Md</b>				d. STREET ADDRESS <b>243 Bloomsbury Avenue</b>			
				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print)		First <b>JAMES</b> Middle <b>ALFRED</b> Last <b>MEYER</b>		4. DATE OF DEATH		Month <b>April</b> Day <b>12</b> Year <b>19 60</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>April 11, 1960</b>		9 AGE (In years lost birthday) yrs	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>N/A</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Alfred Meyer</b>				14. MOTHER'S MAIDEN NAME <b>Edna Earle Harrell</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>N/A</b>		17. INFORMANT <b>Mother</b>		Address <b>243 Bloomsbury Avenue</b> <b>Havre de Grace, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory distress syndrome</b> <b>756.2</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Congenital anomalies of GU tract and possibly intestinal tract</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>11 hrs 15 min</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Hour a. m. p. m.		20d INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <del>XX</del> (this hospital) attended the deceased from <b>11 April 19 60</b> to <b>12 April 19 60</b> , that (I) <del>was</del> <b>was</b> last saw the deceased alive on <b>12 April 19 60</b> and that death occurred <b>8:30AM</b> from the causes and on the date stated above							
22a SIGNATURE <b>Thomas J Fraher</b> M D				ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b DATE SIGNED <b>12 Apr 60</b>	
22c PHYSICIAN'S NAME (Type) <b>THOMAS J FRAHER Capt MC</b>				22d ADDRESS <b>US Army Hospital Aberdeen Proving Ground, Maryland</b>			
23a BURIAL, CREMATION, REMOVA. (Specify)		23b DATE THEREOF <b>4/13/60</b>		23c NAME OF CEMETERY OR CREMATORY <b>Angel Hill</b>		23d LOCATION (City, town or county) (State) <b>Harford County Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Bennington &amp; Son</b>				ADDRESS <b>Havre de Grace Md</b>		25a REC'D BY REGISTRAR <b>APR 18 '60</b>	
						25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

756.2

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

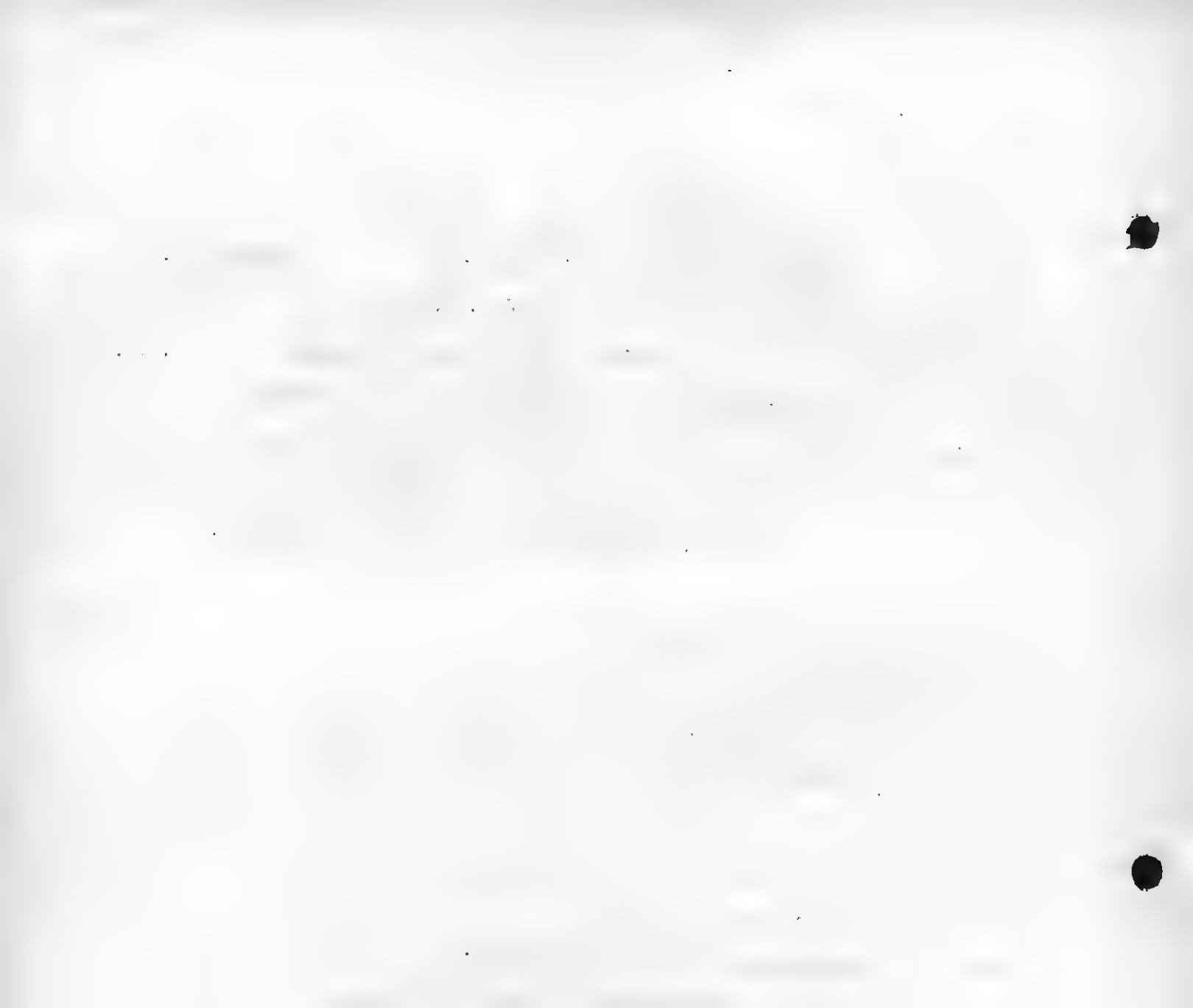
4613

## CERTIFICATE OF DEATH

64567  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harvey, Md.</u> c. LENGTH OF STAY IN lb. <u>Apr. 4-27-60</u> d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Harford Memorial Hospital</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Harford</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Abingdon</u> d. STREET ADDRESS <u>58B 289 Rt. # 1</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Frank</u> Middle <u>Pacholik</u> Last <u>Pacholik</u>		4. DATE OF DEATH <u>April</u> Month <u>27</u> Day <u>30</u> Year <u>1960</u>	
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 8, 1870</u>	
9. AGE (In years last birthday) <u>90</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Tailor</u>	
11. BIRTHPLACE (State or foreign country) <u>Europe (Czech)</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S M.A.DEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO <u>none</u>	
17. INFORMANT <u>Frank A. Pacholik - son - same</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Empyema, left</u> DUE TO (b) <u>Bronchopneumonia, left</u> DUE TO (c) <u>4 days</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>O.A.S.C.V.D. &amp; bleeding hemorrhoid</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4/27</u> , 19 <u>60</u> , to <u>4/30</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>4/30</u> , 19 <u>60</u> , and that death occurred at <u>10:34</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edward C. Lee, M.D.</u>		ADDRESS (Street, city or town, state) <u>211 N. Union Ave., Harford, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Edward C. Lee, M.D.</u>		DATE SIGNED <u>4/30/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 3, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Oak Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u>	
23a. FUNERAL DIRECTOR'S SIGNATURE <u>Howard K. McCombs Jr.</u>		23b. ADDRESS <u>Abingdon, Md.</u>	
24a. REC'D BY REGISTRAR <u>DATE MAY 4 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Kline</u>	

TO NOTARY OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4614

## CERTIFICATE OF DEATH

64588  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford Maryland</u>				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hardec Chase</u>		c. LENGTH OF STAY IN TB <u>20 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hardec Chase</u>		27	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>—</u>				d. STREET ADDRESS <u>1000 Chesapeake Drive</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Jason J. Pate</u>				4. DATE OF DEATH Month <u>4</u> Day <u>2</u> Year <u>1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/18/1915</u>		9. AGE (In years last birthday) <u>44</u> yrs.	IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> M.n. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>President</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Chesapeake Broadcasting Corp.</u>		11. BIRTHPLACE (State or foreign country) <u>Montezuma, Ga.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel J. Pate</u>				14. MOTHER'S MAIDEN NAME <u>Pauline Franklin</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Virginia L. Pate</u> Address <u>1000 Chesapeake Drive Hardec Chase, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple Cerebral Hemorrhage</u> 351X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Essential Hypertension</u> DUE TO (c) <u>—</u>							INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>6 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>			
20c. TIME OF INJURY Month <u>—</u> Day <u>—</u> Year <u>19</u> Hour <u>—</u> a. m. <u>—</u> p. m. <u>—</u>			20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) <u>—</u> (County) <u>—</u> (State) <u>—</u>
21. I certify that I attended the deceased from <u>3/23rd</u> , 19 <u>60</u> , to <u>4/2nd</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>4/2nd</u> , 19 <u>60</u> , and that death occurred at <u>10:10 PM</u> , from the causes and on the date stated above ADDRESS (Street, city or town, state) <u>—</u> DATE SIGNED <u>4/4/60</u>							
ACTUAL SIGNATURE <u>Edward C. Bloom</u> M.D. <u>—</u>							
PHYSICIAN'S NAME (Type) <u>DR. EDWARD C. BLOOM</u>							
22. BURIAL, CREMATION, REMOVAL (Specify) <u>—</u>		22b. DATE THEREOF <u>4/6/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bellin Memorial Park, Bel Air, Md.</u>		22d. LOCATION (City, town, or county) (State) <u>—</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>—</u>				24a. REC'D BY REGISTRAR DATE <u>APR 7 '60</u>		24b. REGISTRAR'S SIGNATURE <u>—</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4636

## CERTIFICATE OF DEATH

64589

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BEL AIR RURAL</u>		c. LENGTH OF STAY IN 1b <u>14 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Churchville Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>HENRY</u> Middle <u>R.</u> Last <u>PETERS</u>		4. DATE OF DEATH Month <u>April</u> Day <u>3</u> Year <u>1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 4, 1877</u>
9. AGE (In years last birthday) <u>83</u> yrs		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	IF UNDER 24 HRS Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Agriculture</u>	
11. BIRTHPLACE (State or foreign country) <u>Floyd County, Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Moses Peters</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Trusler</u> RD. #2 Bel Air, Md.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-24-9967</u>	
17. INFORMANT <u>Mrs. Zula E. Thomas Peters</u>		Address <u>  </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ileumia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CVA</u> DUE TO (c) <u>arteriosclerosis - essent. hypertension</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>N/A</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2-3 days</u> <u>10 days</u> <u>sev. yrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>N/A</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>N/A</u> 19 <u>  </u> p. m. <u>  </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) (County) (State) <u>  </u>	
21. I certify that I attended the deceased from <u>31 Mar</u> , 19 <u>60</u> , to <u>31 Mar</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>31 MAR</u> , 19 <u>60</u> , and that death occurred at <u>5:30</u> AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Bel Air, Md.</u> DATE SIGNED <u>4/14/60</u>			
ACTUAL SIGNATURE <u>Warren R. Lesch, M.D.</u> M.D. <u>115 Juleford Ave, Bel Air, Md.</u>		DATE SIGNED <u>4/14/60</u>	
PHYSICIAN'S NAME (Type) <u>WARREN R. LESCH, M.D.</u>		DATE SIGNED <u>4/14/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>April 5, 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>BEL AIR RD., Harford Co., Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph W. Truster</u>		24a. REC'D BY REGISTRAR DATE <u>APR 5 '60</u>	
ADDRESS <u>W. Broadway + Williams St., BEL AIR, Maryland</u>		24b. REGISTRAR'S SIGNATURE <u>William J. Truster</u>	



4615

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

64590

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>N. Y.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hanover</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brooklyn 59</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Hanover Memorial Hospital</u>		d. STREET ADDRESS <u>871 Fox St</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Melvin Schwartz</u>		4. DATE OF DEATH Month Day Year <u>April 1 1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/20/1937</u>
9. AGE (In years last birthday) <u>22</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Helper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Chumking</u>	11. BIRTHPLACE (State or foreign country) <u>New York</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Julius Schwartz</u>		14. MOTHER'S MAIDEN NAME <u>Bessie Podrid</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Charles Albert</u>		Address <u>115 W. 79th St. New York</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture skull</u> <u>815X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Motorcycle accident with m.v.</u>	
20c. TIME OF INJURY Hour <u>4</u> a.m. <u>pm</u> Month, Day, Year <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Rte 40</u>	20f. (City or town) (County) (State) <u>Nr. H. 161</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Gerald E Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <u>Beltin, N.Y.</u> DATE SIGNED <u>4-1-60</u>	
EXAMINER'S NAME (Type) <u>Gerald E Palmer</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>4/3/60</u>	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY <u>Sharon Gardens</u>	22d. LOCATION (City, town, or county) (State) <u>New York N.Y.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Benjamin R. R. Hanover</u>		ADDRESS	
24a. REC'D BY REGISTRAR <u>DATE APR 4 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Nathan S. Hines</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



463  
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgewood</u>				c. LENGTH OF STAY IN 1b <u>1 yr.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>Edgewood, 25 Starr St.,</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>E.</u> Last <u>Smith</u>				4. DATE OF DEATH Month <u>April</u> , Day <u>9</u> Year <u>1960</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Mar. 25, 1959</u>	
9. AGE (In years last birthday) <u>1</u> yrs		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>		IF UNDER 24 HRS Hours <u>  </u> Min <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.,</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.,</u>							
13. FATHER'S NAME <u>John L. Smith</u>				14. MOTHER'S MAIDEN NAME <u>Mary L. Dillon</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO <u>none</u>		17. INFORMANT <u>John L. Smith</u> Address <u>Edgewood Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aspiration of Foreign Body</u> 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pneumonia</u> DUE TO (c) <u>Cerebral Palsy</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>4/6</u> , 19 <u>60</u> , to <u>4/9</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>4/8</u> , 19 <u>60</u> , and that death occurred at <u>11 P.</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Edgewood Maryland</u> DATE SIGNED <u>E. Louis Kahan</u>							
ACTUAL SIGNATURE <u>E. Louis Kahan</u>							
PHYSICIAN'S NAME (Type) <u>E. Louis Kahan</u>				<u>Edgewood Maryland</u>			
22a. BURIAL, CREMAT. OR REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Apr. 11, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Chokesbury Memorial</u>		22d. LOCATION (City, town, or county) (State) <u>Abingdon, Harford, Md.,</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard K. Kahan</u>				ADDRESS <u>Abingdon, Maryland.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 13 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>C. L. Kahan</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

4011

4616

CERTIFICATE OF DEATH

04593

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Hartford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre de Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Forest Hill</u>	
c. LENGTH OF STAY IN 1b <u>7 days.</u>		d. STREET ADDRESS <u>1</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hartford Mem. Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Preston</u> Last <u>Smithson</u>		4. DATE OF DEATH Month <u>April</u> Day <u>20</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/25/84</u>
9. AGE (In years last birthday) <u>76</u> yrs		10. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Smithson</u>		14. MOTHER'S MAIDEN NAME <u>Sophia ?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>01-10-10000</u>	
17. INFORMANT <u>Olyer Boyer</u>		Address <u>Forest Hill, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myeloid Leukemia, Aleukemic</u> <u>Stage 2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>  </u> DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus and A.S.C.V.D. (Arteriosclerosis)</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>		20c. TIME OF INJURY Month <u>  </u> Day <u>  </u> Year <u>19</u> Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	
20f. (City or town) <u>  </u>		(County) (State)	
21. I certify that I attended the deceased from <u>April 13, 1960</u> to <u>April 20, 1960</u> , that I last saw the deceased alive on <u>April 20, 1960</u> , and that death occurred at <u>11:00 A.M.</u> from the causes and on the date stated above.			
22. ACTUAL SIGNATURE <u>Edward C. Fao, MD</u>		23. ADDRESS (Street, city or town, state) <u>Harre de Grace, Md.</u>	
24. DATE SIGNED <u>4/20/60</u>		25. PHYSICIAN'S NAME (Type) <u>Edward C. Fao, MD</u>	
26. BURIAL, CREMATION, REMOVAL (Specify) <u>buried</u>		27. DATE THEREOF <u>April 22, 1960</u>	
28. NAME OF CEMETERY OR CREMATORY <u>Forest Hill Cemetery</u>		29. LOCATION (City, town, or county) (State) <u>Forest Hill, Md.</u>	
30. FUNERAL DIRECTOR'S SIGNATURE <u>H. S. Bailey</u>		31. ADDRESS <u>Washington, Md.</u>	
32. REC'D BY REGISTRAR DATE <u>APR 25 '60</u>		33. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



4617

## CERTIFICATE OF DEATH

64594

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Hartford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Havre de Grace</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Perryman</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hartford Mem. Hosp.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Prince - Albert - Stansbury</u>				4. DATE OF DEATH Month Day Year <u>April 20 1960</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Oct-10-1902</u>	9. AGE (In years lost birthday) <u>57</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Day laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Farm/Coaching Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Geo. Stansbury</u>				14. MOTHER'S MAIDEN NAME <u>Susan Clark</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>218-03-8519</u>			
17. INFORMANT Address <u>Olevia Stansbury - Box 156 Perryman Md.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma of the Pancreas</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH _____
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____
20c. TIME OF INJURY Hour a. m. _____ p. m. _____ Month, Day, Year _____ 19 _____			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>1/4</u> , 1960, to <u>4/20</u> , 1960 that I last saw the deceased alive on <u>4/20</u> , 1960, and that death occurred at <u>6:10 AM</u> , from the causes and on the date stated above ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>George T. Stansbury, M.D. 569 Revolution St. Havre de Grace, Md. 4/20/60</u> PHYSICIAN'S NAME (Type) <u>George T. Stansbury</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/23/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Union Methodist</u>		22d. LOCATION (City, town, or county) (State) <u>Aberdeen, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John E. Sarring</u>				ADDRESS <u>Aberdeen, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>APR 25 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.



4603

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>32 BEL Air</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>206 Hickory Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Leah</u> Middle <u>L.</u> Last <u>Stehley</u>		4. DATE OF DEATH Month <u>April</u> Day <u>11</u> Year <u>1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 3, 1885</u>
9. AGE (In years last birthday) <u>75</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housework</u>	
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Lantz</u>		14. MOTHER'S MAIDEN NAME <u>Georgiana Barr</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT (Daughter) <u>Mrs. Thelma Herbert</u>		Address <u>206 Hickory Avenue</u> <u>Bel Air, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Metastatic CA to VITAL ORGANS</u> <u>199.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>PRIMARY CA - UNKNOWN</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>8 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>PROFOUND CACHEXIA</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>N/A</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>10 April, 1960</u> , to <u>11 April, 1960</u> , that I last saw the deceased alive on <u>11 APR - 2 AM</u> , 1960, and that death occurred at <u>5:30 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Warren R. Lesch, MD</u> M.D.		DATE SIGNED <u>115 July - Bel Air, MD - 4/11/60</u>	
PHYSICIAN'S NAME (Type) <u>WARREN R. LESCH, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>April 14, 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Greenwood Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Altoona</u> <u>Pennsylvania</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph W. Foster</u>		24a. REC'D BY REGISTRAR DATE <u>Apr 13 '60</u>	
ADDRESS <u>W. Broadway + W. Filliams Street</u> <u>BEL Air, Maryland</u>		24b. REGISTRAR'S SIGNATURE <u>Clifton S. Thomas</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

199.2

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4599

## CERTIFICATE OF DEATH

Reg. Dist. No.

64596

1. PLACE OF DEATH a. COUNTY <b>Harford</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived IF institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Aberdeen</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>31 Aberdeen</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>31 E. Bel Air Ave.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>EUNICE</b> Middle <b>JAMISON</b> Last <b>VIELE</b>				4. DATE OF DEATH Month <b>April</b> Day <b>15</b> Year <b>1960</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 25, 1884</b>		9. AGE (In years last birthday) <b>75</b> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House-wife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>David Jamison</b>			
14. MOTHER'S MAIDEN NAME <b>Mary Robinson</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			
16. SOCIAL SECURITY NO. <b>*** **</b>				17. INFORMANT <b>Frederick J. Viele, Havre de Grace, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Inanition</b> DUE TO (b) <b>Chronic Diarrhea</b> DUE TO (c) <b>Recurrent carcinoma, rectosigmoid</b> INTERVAL BETWEEN ONSET AND DEATH <b>1 yr.</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>1950</b> to <b>1-15-60</b> , that I last saw the deceased alive on <b>1-15-60</b> , and that death occurred at <b>9:00 PM</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>8 Law Street</b> DATE SIGNED <b>April 16, 1960</b>							
ACTUAL SIGNATURE <b>Peter P. Rodman, M.D.</b>				PHYSICIAN'S NAME (Type) <b>Aberdeen, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/18/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Grove Cemetery</b>		22d. LOCATION (City, town or county) (State) <b>Aberdeen, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John D. Tarring</b>				24a. REC'D BY REGISTRAR <b>APR 20 80</b>		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

1/19/01

4613

CERTIFICATE OF DEATH

64597

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Hartford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hartford de Grace</u>		c. LENGTH OF STAY IN 1b <u>28 hrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hartford Memorial H</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hartford de Grace</u>	
f. STREET ADDRESS <u>310 N. Stokes St.</u>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Baby Girl WALLS</u>		4. DATE OF DEATH Month <u>4</u> Day <u>17</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/16/60</u>
9. AGE (In years last birthday) yrs. <u>4</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>1</u> Days <u>4</u> Hours <u>22</u> Min <u>22</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>MD</u>	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Dean L. Barrett</u>		14. MOTHER'S MAIDEN NAME <u>Marian Lloyd</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Marian Walls. 310 N. Stokes St.</u>	
17. INFORMANT Address <u>Marian Walls. 310 N. Stokes St.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Subarachnoid Hemorrhage</u> 760.5 DUE TO (b) <u>Prematurity</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (b) _____ DUE TO (c) _____	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on <u>April 17</u> , 19 <u>60</u> , and that death occurred at <u>5:22 P.M.</u> from the causes and on the date stated above ADDRESS (Street, city or town, state) _____ DATE SIGNED _____			
ACTUAL SIGNATURE <u>[Signature]</u> M.D. _____			
PHYSICIAN'S NAME (Type) _____			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>4-18-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Hartford Memorial Hospital</u>		22d. LOCATION (City, town, or county) (State) <u>Hartford de Grace, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harry R. [Signature]</u> ADDRESS _____		24a. REC'D BY REGISTRAR <u>Arthur S. [Signature]</u> DATE <u>APR 22 '60</u>	
24b. REGISTRAR'S SIGNATURE _____		24c. _____	

None

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4619

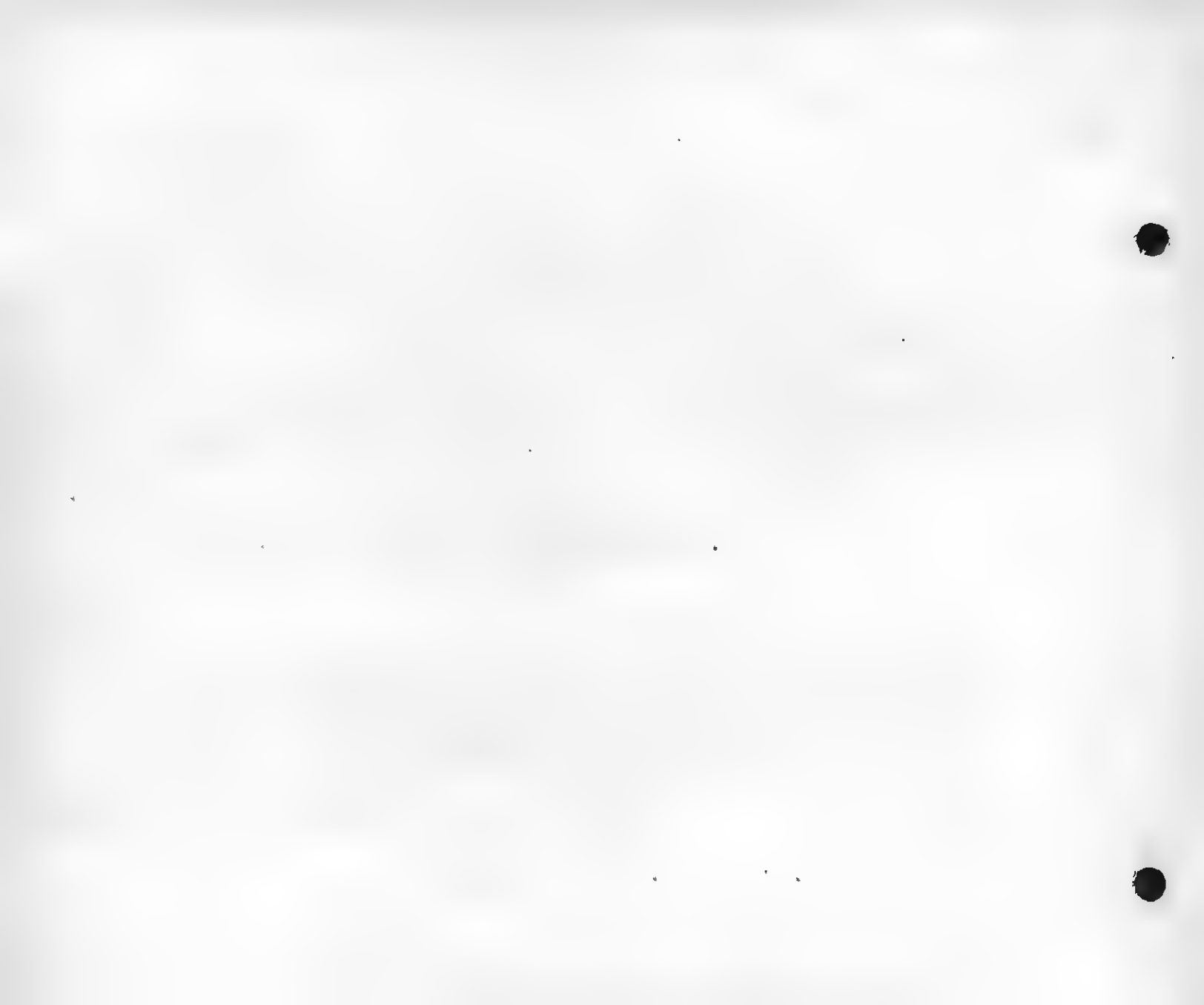
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hosp</u>		e. STREET ADDRESS <u>Box 425 J Rt #1</u>	
3. NAME OF DECEASED (Type or print) <u>John Sawyer Walter</u>		4. DATE OF DEATH <u>April 24, 1960</u>	
5. SEX <u>male</u>	6. COLOR OF RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 2, 1896</u>
9. AGE (In years last birthday) <u>64</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Building</u>	
11. BIRTHPLACE (State or foreign country) <u>N. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Robert Lee Walters -</u>		14. MOTHER'S MAIDEN NAME <u>Emmie Gene Hudson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <u>yes.</u> <u>WW I</u>		16. SOCIAL SECURITY NO <u>INFORMANT</u> <u>R. Henry Walters</u> Address <u>Fallston Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chr. hypertensive cardio-vascular disease.</u> DUE TO (c) <u>?</u>		24 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 3, 1959</u> to <u>April 24, 1960</u> that I last saw the deceased alive on <u>23 April, 1960</u> and that death occurred at <u>8:15 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Willard P. Hudson</u> M.D.		DATE SIGNED <u>April 25, 1960</u>	
PHYSICIAN'S NAME (Type) <u>Willard P. Hudson, M.D.</u>		ADDRESS (Street, city or town, state) <u>Forest Hill, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/26/1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>McLean</u>	22d. LOCATION (City, town, or county) (State) <u>Fountain Green Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles E. Ruff</u> ADDRESS <u>Garrettsville Md</u>		24a. REC'D BY REGISTRAR DATE <u>APR 27 '60</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kimes</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



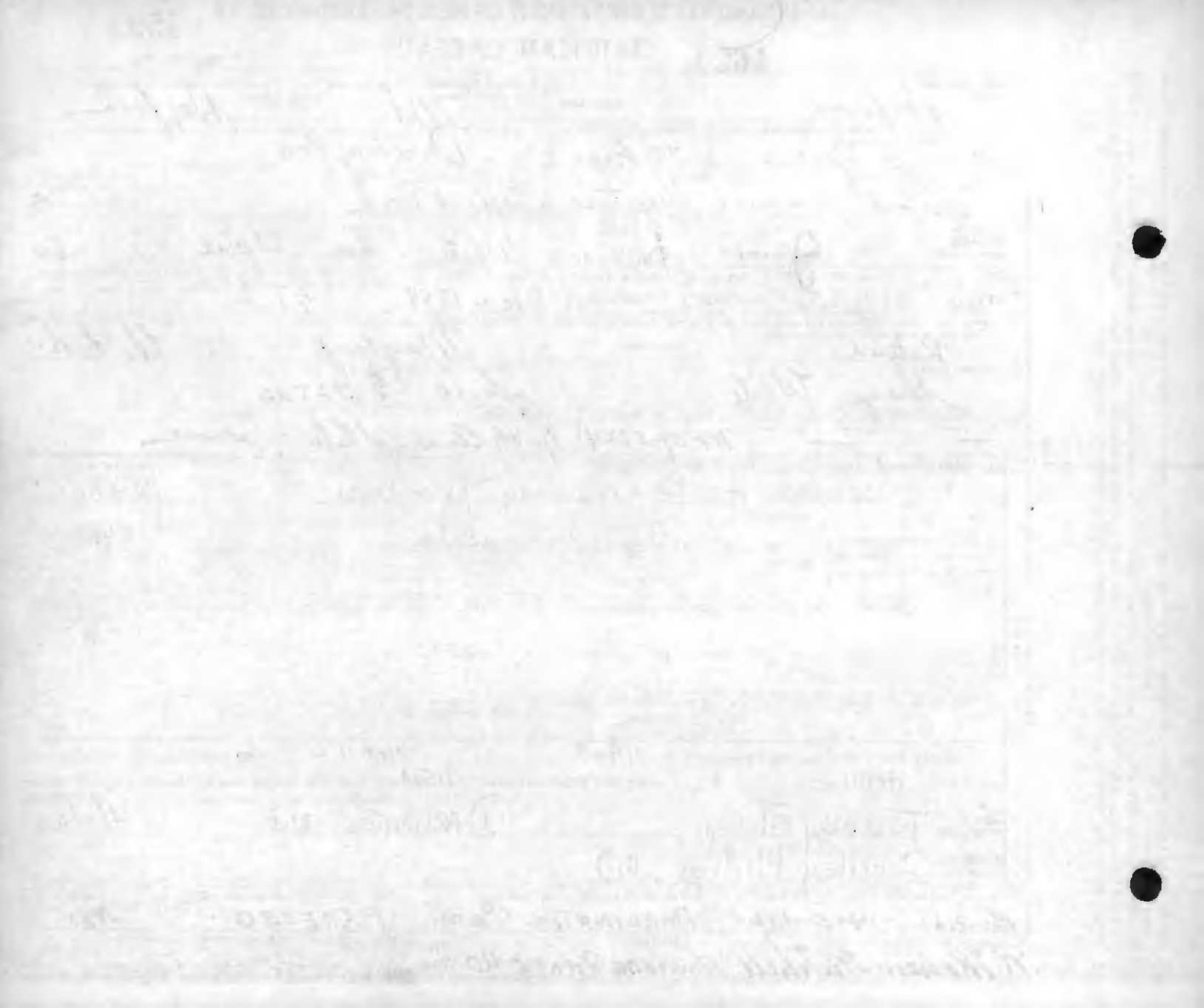
## 4620 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harpford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Harpford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Garre de Grace</u>				c. LENGTH OF STAY IN 1b <u>72 hrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Harrison</u> Last <u>White</u>				4. DATE OF DEATH Month <u>April</u> Day <u>2</u> Year <u>1960</u>			
5. SEX <u>male</u>		6. COLOR OF RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 4, 1888</u>	
9. AGE (In years lost birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>1</u> Hours <u>1</u> Min. <u>0</u>		IF UNDER 24 HRS. Hours <u>1</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>George White</u>				14. MOTHER'S MAIDEN NAME <u>Sarah GATES</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service) <u>—</u>				16. SOCIAL SECURITY NO. <u>717-07-5724</u>			
17. INFORMANT <u>Beth Ann White - same</u>				Address <u>—</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE Coronary Thrombosis</u> <u>420.1</u> DUE TO <u>GENERALIZED Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO <u>—</u> (c) <u>—</u>							INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> <u>10 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>—</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>	
20f. (City or town) <u>—</u> (County) <u>—</u> (State) <u>—</u>							
21. I certify that I attended the deceased from <u>1947</u> , 19 <u>—</u> to <u>APRIL 2</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>APRIL 2</u> , 19 <u>60</u> , and that death occurred at <u>1150 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Dudley Phillips</u> M.D. <u>DARLINGTON MD</u>				DATE SIGNED <u>4/2/60</u>			
PHYSICIAN'S NAME (Type) <u>Dudley Phillips MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4-5-1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>DARLINGTON CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>HARFORD MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. Madison Mitchell</u> ADDRESS <u>HARFORD GRACE MD.</u>				24a. REC'D BY REGISTRAR <u>APR 6 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kneass</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



2 1  
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

64600

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Penn.</u> COUNTY <u>Reading</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Reading</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Smith Chapel Methodist Church</u>		d. STREET ADDRESS <u>520 S. 17th. Street</u> 75X-3	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Yez</u> Last <u>Yez</u>		4. DATE OF DEATH Month <u>April</u> Day <u>25</u> Year <u>1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/27/1893</u>
9. AGE (In years last birthday) <u>66</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist Retired</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>	
11c. BIRTHPLACE (State or foreign country) <u>Poland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Blazey Yez</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>160-18-7930</u>	
17. INFORMANT <u>Robert Beekley, Havre de Grace #2, Md.</u>		Address <u>  </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic C.V. disease</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u> INTERVAL BETWEEN ONSET AND DEATH <u>  </u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>	
20c. TIME OF INJURY Hour <u>  </u> o. m. <u>  </u> p. m. <u>  </u> 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) <u>  </u> (County) <u>  </u> (State) <u>  </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Gerald C Palmer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air, Md</u> DATE SIGNED <u>4-26-60</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>4/26/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Stephens Polish</u>		22d. LOCATION (City, town, or county) <u>Reading Penna.</u> (State) <u>  </u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John F. Tarring</u> ADDRESS <u>Aberdeen, Md.</u>		24. REC'D BY REGISTRAR <u>APR 29 '60</u> DATE <u>  </u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		24c. REGISTRAR'S SIGNATURE <u>  </u>	

MISSISSIPPI STATE DEPARTMENT OF HEALTH - BUREAU OF VITALS  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Death	
Last Name, First Name, Middle Initial		Male / Female		Years, Months, Days		Month, Day, Year	
Place of Birth		Usual Residence		Cause of Death		Manner of Death	
County, State		City, Town, Village, or Post Office		Disease or Injury		Suicide, Homicide, Accident, or Natural	
Occupation		Education		Medical History		Previous Illnesses	
Social Security Number		Marital Status		Date of Admission to Hospital		Date of Discharge	
Signature of Medical Examiner		Signature of Coroner		Signature of Registrar		Signature of Clerk	
Date of Examination		Date of Coroner's Report		Date of Registrar's Report		Date of Clerk's Report	
Official Seal of Medical Examiner		Official Seal of Coroner		Official Seal of Registrar		Official Seal of Clerk	